



Prescribing Guidelines for Pennsylvania



GERIATRIC PAIN Opioid Use and Safe Prescribing

These guidelines are intended to help health care providers improve patient outcomes when providing this treatment, including avoiding potential adverse outcomes associated with the use of opioids to treat pain.

These guidelines are intended to supplement and not replace the individual prescriber's clinical judgment.

BACKGROUND - Chronic pain is one of the major health problems in the United States, occurring with a point-prevalence of about one-third of the US population. Chronic pain in the elderly has been

estimated to be as high as 57% by the Institute of Medicine.

Pain is common in older adults due to the increased prevalence of painful conditions that are associated with aging. It may be under recognized, and under treated due to the reticence of some older adults to report pain and because providers may have been undereducated about chronic pain evaluation and management.

Prescription opioid abuse has become an issue of national importance as drug overdose is the leading



cause of accidental death in adults living in America. Providers have been encouraged to treat pain aggressively. Pain has been described as “the fifth vital sign” and while this is a useful approach for treating acute pain such as post-trauma pain or surgical pain, it is less useful for those with chronic non-cancer pain. Despite the good intentions of the medical community a deadly epidemic of addiction and misuse of opioid prescription medication has occurred. In order to help stem this epidemic, there has been a call for more judicious prescribing on the part of physicians and other health-care providers. By following guidelines, providers can play a role in guiding safe and effective pain treatment.

OBJECTIVE - This guideline will highlight special problems concerning using opioids when treating older adults for chronic non-cancer pain. The use of opioids in the treatment of cancer related pain and end of life pain is beyond the scope of this guideline

Providers should review associated Pennsylvania state guidelines related to the use of opioids in different patient populations. These other guidelines contain important information that may be relevant to this patient population.

Providers should remember that exercise, physical therapy, or psychological therapy such as cognitive behavioral therapy will often ameliorate pain and improve function. In many situations, these approaches should be tried first and only then should pharmacologic agents be considered rather than other methods of pain management.

The GUIDELINES

1. Chronic pain is a biopsychosocial syndrome that may benefit from several different types of non-pharmacological treatments used separately or together. Reliance on medication alone can result in inadequate pain control and the potential for harm.
2. Chronic opioid therapy is a common treatment option for chronic pain. The use of opioids has increased despite limited evidence of safety and long term efficacy.
3. Starting therapy for chronic pain with long acting opioids should be avoided in older adults.
4. Low-dose, as-needed opioids may be a reasonable treatment option for such conditions as peripheral neuropathic pain or for the severe pain related to hip or knee osteoarthritis that is not amenable to surgery.
 - In these situations, older adults should be counselled of the risks and potential benefits associated with this treatment. Reasonable goals and expectations for treatment should be agreed upon by provider and patient.
 - The adverse side effects of chronic opioids may impair physical and mental functioning. Opioid administration can cause impaired cognitive functioning. In addition, patients on chronic opioids appear to have a significantly increased risk of fractures that appears to be due at least in part to an increased risk of falls.
 - Opioids are not a first line medication for the treatment of neuropathic pain. Non-opioid medications, including transdermal products, should be considered for the treatment of neuropathic pain before the use of opioids is considered.
5. Daily pill box organizers are recommended for older adults with cognitive impairment or dementia. Older adults with cognitive impairment are at higher risk of either omitting or taking extra medications. When appropriate, providers should encourage caregivers to assist the patient in taking prescribed medications to ensure proper dosing. Documentation of medication dosing, especially with regard to medications taken on an



as-needed basis, may avoid unintentional overuse of these medications, as opioids taken on an as-needed basis are more likely to be taken incorrectly.

6. When opioid therapy is indicated it should be started at 25 to 50% of the usual adult dose and titrated slowly. Start low and go slow.
 - Rarely are doses of oral morphine sulfate equivalents of 60 mg a day or more necessary. If dosages of oral morphine sulfate equivalents reach 100 mg daily, then tapering or referral to a pain specialist should be considered.
 - High doses of opioids are not associated with improved efficacy as documented by improvements in pain report or physical and mental functioning. However, high doses of opioids are associated with increased risk of opioid-induced adverse effects, including impairment of cognitive functioning, increased risk for aberrant drug-related behaviors (which do occur in the older adult), and death. In addition, high doses of opioids increases the possibility of opioid-induced hyperalgesia, which can be effectively treated by lowering the prescribed opioid dose.
7. Prescribers should consider starting treatment for opioid-induced constipation when opioid therapy is started, since this side effect is common and will not resolve with time.
 - Usual practice is to start a stimulant laxative, such as senna, at the same time as starting an opioid.
 - If opioid induced obstipation is not properly treated, this condition may require hospitalization due to functional obstruction.
8. The use of opioids is associated with a significantly increased risk of fractures.
 - The risk of fractures may be due to cognitive impairment during the first 2 weeks of opioid therapy, as well as the long-term endocrine effects of the opioid.
 - Patients should be informed of this risk, and care should be taken to avoid the risk of fractures at the initiation of opioid therapy as well as during chronic therapy. Prescribers should carefully consider the increase in risk of fractures with opioid administration, which likely is more common in the older adult, when weighing the potential for benefit with the risk of harm with chronic opioid therapy.
9. Up to 80% of individuals experience adverse effects with chronic opioid therapy. In addition to the risk of falls and fractures, these risks include somnolence, sleep disordered breathing, dizziness, hypogonadism, nausea, vomiting, erectile dysfunction, and pruritus.
 - The risk for adverse effects increases with increased opioid dose.
 - The risk of opioid-related respiratory depression is increased in individuals with obstructive sleep apnea, central sleep apnea, chronic obstructive respiratory disease, and those individuals taking benzodiazepines or other centrally-acting sedatives.
10. Older adults receiving opioids for chronic pain should be made aware of the risk of overdose. Providers should consider providing a prescription for naloxone to family members for emergent treatment of overdose.
11. Prescribers should inform older adults that all medications, especially opioids should be stored in a safe place, out of the reach of children.
 - The dosages of opioids that are prescribed for adults can be fatal for children. Because many



people who develop opioid substance use disorder get their initial supplies from the medicine cabinets of family members, it is important that abusable medications be kept in a safe place to avoid diversion.

12. Older adults should be made aware of the danger of their medications being pilfered and sold for gain by relatives or caregivers. Having opioids in the home of older adults can cause them to be the victims of crime by persons attempting to steal their medications.

- Prescribers should be aware that older adults with cognitive deficits or dementia are at special risk of having their opioids diverted.

13. It is important to continue opioids only when the patient is clearly benefiting from them through improvements in reported pain intensity and physical and mental functioning. When opioids are no longer necessary, they should be disposed of in a safe manner. Pennsylvania maintains drug take back centers. To find one near you follow this link:

http://www.ddap.pa.gov/Prevention/Pages/Drug_Take_Back.aspx#.VkuSP5go6Uk

14. Addiction to opioids is always a concern.

- Consider using medication agreements which allow for urinary drug screening. Monitoring for symptoms of addiction and/or diversion (complaints of increasing tolerance, aberrant medication behaviors, and/or unexpected findings on urine drug screens) should occur throughout treatment with opioids.
- Patients demonstrating symptoms of moderate to severe aberrant drug-related behavior or substance use disorder should be referred for proper assessment and treatment. In general, opioids should not be continued in patients with active substance use disorder. The use of

screening tools for opioid misuse should be considered prior to and after initiating opioids.

[Ehttp://partnersagainstpain.com/hcp/pain-assessment/tools/#screening_tools](http://partnersagainstpain.com/hcp/pain-assessment/tools/#screening_tools))

15. Providers should warn older adult patients that combining opioids with alcohol is dangerous and can be fatal because older adult patients will have higher alcohol levels than younger patients with an equivalent amount of alcohol.

16. Opioids should not be prescribed as a sedative, or a soporific. Extreme caution should be exercised when combining opioids with benzodiazepines or soporifics. Special caution is warranted when older adults take PRN dosages in addition to the prescribed dosages.

17. Opioids should not be prescribed by multiple providers. One provider should be responsible for writing all opioid prescriptions for older adult patients because they are likely to be seeing multiple providers and receiving multiple medications. It is never appropriate to ask emergency department physicians to prescribe opioid renewals.

STEPS TO TREAT OLDER ADULT PATIENTS

1. Before starting prescription drugs there should be an evaluation and treatment of the condition(s) causing the pain. Clinicians should conduct and document a history, including documentation and verification of current medications, and a physical examination. The initial evaluation should include documentation of the patient's psychiatric status and substance use history.
2. Patients with chronic non-cancer pain should be counseled about realistic treatment expectations. The goal is the reduction of pain with significantly improved ability to function despite the persistence of some pain. Such counseling may help to avoid future futile drug prescribing.



- Exercise, physical and occupation therapy, and cognitive behavioral therapy have been shown to reduce pain and improve function in patients with chronic non-cancer pain.
 - Alternative therapies such as medication, massage, acupuncture, and yoga may be useful, depending on the cause(s) of pain.
3. This guideline does not address the complete topic of pharmacologic control of pain in older adults. However, because older adults who take opioids also frequently take acetaminophen, practitioners should be aware of the dangers attributable to acetaminophen.
- Practitioners should be aware that acetaminophen may cause hepatic toxicity and the daily dose of acetaminophen for older adult patients should usually not exceed 3000 mg a day, less for patients who have liver disease or are frail.
 - Acetaminophen is a constituent of many over-the-counter medications. Prescribers of opioids should ask about acetaminophen use because many people do not consider over-the-counter products to be drugs and do not mention them to their prescribers unless asked.
 - There are some commonly prescribed opioids that have formulations that contain acetaminophen. Because of the many forms in which patients may be taking acetaminophen, the maximum safe daily dosage can be easily exceeded.

For more information and details, providers may consult “Managing Pain in the Elderly” a publication of the Alosa Foundation supported by the Pharmaceutical Assistance Contract for the Elderly of the Pennsylvania Department of Aging. The link is: <http://www.alosafoundation.org/clinical-material/>

References

Trends in Opioid Analgesic Abuse and Mortality in the United States. *New England Journal of Medicine* 327; 3, 241-248, January 15, 2015

A Startling Injustice: Pain, Opioids, and Addiction. *Annals of Internal Medicine* 2015; 162:651-652

Prescription Opioid Duration of Action and the Risk of Unintentional Overdose among Patients Receiving Opioid Therapy. *JAMA Intern Med* 2015;175:608-15

The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institute of Health Pathways to Prevention Workshop. Chou R, Turner JA, Devine EB, Hansen RN, Sullivan SD, Blazina I, et al. *Ann Intern Med.* 2015;162: 276-286